Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

Respondent Name

AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-10-0924-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "If calculated pursuant to sections 134.404(f)(1)(B) and (g), reimbursement should be $100,418.67." "Carrier's payment of $55,551.61 is still less than the amount that Vista should have been reimbursed if it had not requested that implantables be reimbursed separately under 134.404(f)(1)(B), specifically, $85,305.05." "Therefore, the Carrier is required to reimburse Provider **$100,418.67** pursuant to the Inpatient Fee Guideline, which will result in fair and reasonable reimbursement for the services provided to the injured worker. The Carrier made a partial payment of **$55,551.61**. Therefore, the Carrier is required to reimburse Provider in the amount of **$44,867.06**, plus any and all applicable interest."

Amount in Dispute: $44,867.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It appears that the state erred in calculating the amount owed to the provider because they forgot to subtract the charges for the implant from the bill total charges when using the PC Pricer (or whatever other software they are using). Based on the state's guidelines, charges for the implant are removed from the total bill charges when calculating the DRG payment with separate implant reimbursement. Not removing the implant charge is not complying with the guideline and is reimbursing the provider twice for the implant charges, which also causes the bill to hit an additional outlier calculation. Because separate implant reimbursement is requested, the bill total charges that should be entered into the Medicare pricing software should be 107418.51, not 210035.51."

Response Submitted by: Flahive Ogden & Latson, Attorneys At Law, PC, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 7, 2008 Through October 9, 2008	Inpatient Hospital Surgical Services	$44,867.06	$29,753.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. 28 Texas Administrative Code §134.404(g) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: 'I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge.'"
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 11, 2009
   - F – REIMBURSEMENT HAS BEEN BASED ON THE AVERAGE WHOLESALE PRICE PLUS A MARK-UP AND DISPENSING FEE.
   - 64 – REIMBURSEMENT HAS BEEN CALCULATED BASED ON A DRG ALLOWANCE.

Issues

1. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
2. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
2. Review of the submitted documentation finds that, although the provider requested separate reimbursement for implantables, the provider did not include a certification with the billing that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable(s). The provider did not meet the requirements of §134.404(g). The Division, therefore, concludes that the provider did not request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g).
3. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(A) as follows:

   The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 455 is $59,653.88.

   This amount multiplied by 143% is $85,305.05.

   The total maximum allowable reimbursement (MAR) is $85,305.05.

   This amount less the amount previously paid by the respondent of $55,551.61 leaves an amount due to the requestor of $29,753.44.

   The Division concludes that the requestor is entitled to $29,753.44 additional reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $29,753.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $29,753.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 11, 2011 Date
Signature	Medical Fee Dispute Resolution Manager	October 11, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.